



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Frederick L. Merian, M.D.

**Respondent Name**

American Zurich Insurance Company

**MFDR Tracking Number**

M4-17-0842-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 28, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "THE CARRIER IS DENYING PAYMENT FOR IMPAIRMENT RATING FOR THE HEAD INJURY AS A SEPARATE BODY AREA. THE COMPENSABLE INJURY AND RATED AREAS WERE LEFT WRIST, LEFT HIP, LEFT SHOULDER AND HEAD CONTUSION. THE UPPER EXTREMITY IS ONE BILLABLE AREA, THE LOWER EXTREMITY IS SECOND BILLABLE AREA, AND THE HEAD IS A THIRD BILLABLE AREA."

**Amount in Dispute:** \$150.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This is a fee guidelines dispute. Please see the EOB(s) and the reduction rationale(s) stated therein."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 24, 2015	Designated Doctor Examination	\$150.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers' compensation jurisdictional fee schedule adjustment.
  - 309 – The charge for this procedure exceeds the fee schedule allowance.

## Issues

Did Frederick L. Meridian, M.D. waive the right to medical fee dispute resolution?

## Findings

28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is November 24, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 28, 2016. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The division concludes that Dr. Meridian has failed to timely file this dispute with the division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

## Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## Authorized Signature

_____ Signature	Laurie Garnes _____ Medical Fee Dispute Resolution Officer	December 22, 2016 _____ Date
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## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**